



Date: _____

**Parsons Dermatology and Cosmetics
INTAKE FORM**

Name _____ Birth date (Month/Day/Year): _____

Address: _____ Phone (Home): _____

Phone (Work): _____ Other Contact (email or cell phone) _____

Family Doctor: _____ Referring Doctor: _____

Health Card Number: _____ Pharmacy: _____

Reason for your visit today: _____

AT EACH VISIT ONLY ONE CONCERN WILL BE ADDRESSED

Please list **ALL** medical conditions

Please list **ALL** medications

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Are you **pregnant** or **breastfeeding**? Yes _____ No _____

Are you on a **blood thinner**? (Aspirin, Plavix, Coumadin/Warfarin, other): Yes _____ No _____

Please list **any allergies** to medication: _____

Family History (Please circle any that apply): **Melanoma** **Eczema** **Psoriasis**

COSMETIC SERVICES

Did you know that Dr. Parsons provides many cosmetic services and can help with improving your overall skin health? Please let us know if you're interested in finding our more information about any of the following cosmetic concerns (Please circle):

Acne Scarring

Ageing Skin

Brown Spots

Double Chin

Dull Skin

Facial Volume Loss

Fine lines and Wrinkles

